Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HOUSTON HOSPITAL FOR SPECIALIZED SURGERY

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-0871-01

Carrier's Austin Representative
Box Number: 54

MFDR Date Received
NOVEMBER 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Houston Hospital for Specialized Surgery submitted first claim on 02/08/12 to DME Industrial LLC 13123 W Port Arthur Beaumont, TX 77705 as this was who we were informed to bill)see attached admissions record and surgery scheduling form). After we were informed on 07/18/13 that this claim was not received by Texas Mutual we faxed the claim to Texas Mutual on 07/18/13 and on 8/14/13 (attached are confirmation sheets). Our claim denied on 09/24/13 and 11/04/13 for timely filing."

Amount in Dispute: $6,750.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…2. HOUSTON HOSPITAL FOR SPEC SU submitted its bill to DME Industrial on 2/8/13 based on information provided by the claimant… 8. Texas Mutual did not and does not find the rational given by the requestor the late bill persuasive because DME Industrial is not one of the entities described in subsection (b) that subsection (c) refers to. No payment is due."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
FEBRUARY 5, 2013	HOSPITAL OUTPATIENT SERVICES	$6,750.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was

process properly.
- 724 – No additional payment after a reconsideration of services.

Issues

1. Did the requestor bill the employer?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. Review of the documentation submitted by the requestor finds that the employer, DME Industrial LLC was initially billed.
2. In accordance with 28 Texas Administrative Code 133.20(j) The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following: (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (C) medical dispute resolution as provided by Labor Code §413.031. (2)When a health care provider bills the employer, the health care provider shall submit an information copy of the bill to the insurance carrier, which clearly indicates that the information copy is not a request for payment from the insurance carrier. Review of the submitted documentation finds that the requestor submitted the initial bill to the employer; therefore and has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has waived the right to medical fee dispute resolution. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 13, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.